Research Article

A Descriptive Diagnosis or a Causal Explanation? Accuracy of Depictions of Depression on Authoritative Health Organization Websites

Jani Kajanoja[a], Jussi Valtonen[b, c]

[a] Department of Psychiatry, University of Turku and Turku University Hospital, Turku, Finland

[b] Department of Psychology and Logopedics, Faculty of Medicine, University of Helsinki

[c] Theatre Academy, University of the Arts Helsinki

Short title: Depression: A descriptive diagnosis or a causal explanation?

Corresponding Author: Jani Kajanoja

E-mail address: jani.kajanoja@utu.fi

Keywords: Depression, Diagnostic Systems, Essentialism, Psychiatric Diagnoses, Reification

Abstract

Background: Psychiatric diagnoses are descriptive in nature, but the lay public commonly misconceives them as causal explanations. It is not known whether this logical error, a form of circular reasoning, can sometimes be mistakenly reinforced by health authorities themselves. In this study, we investigated the prevalence of misleading causal descriptions of depression in the information provided by authoritative mental health organizations on widely accessed internet sites.

Methods: We searched for popular websites managed by leading mental health organizations and conducted a content analysis to evaluate whether they presented depression accurately as a description of symptoms, or inaccurately as a causal explanation.

Results: Most websites used language that inaccurately described depression as a causal explanation to depressive symptoms.

Conclusion: Leading professional medical and psychiatric organizations commonly confound depression, a descriptive diagnostic label, with a causal explanation on their most prominently accessed informational websites. We argue that the scientifically inaccurate causal language in depictions of psychiatric diagnoses is potentially harmful because it leads the public to misunderstand the nature of mental health problems. Mental health authorities providing psychoeducation should clearly state that psychiatric diagnoses are purely descriptive to avoid misleading the public.

Introduction

Diagnostic classification in psychiatry is under active debate. Recent discussions of psychiatric diagnoses have both identified limitations in current classification systems [1-6] and offered proposals for alternative approaches [7-12]. While many valuable points have already been made, one important aspect about how diagnostic classifications are used in practice has received little attention. That is, regardless of which diagnostic system is used, it is important not to confound purely descriptive diagnostic labels with causal[1] explanations.

Ideally, a medical diagnosis both provides a precise term for a given condition and identifies its etiological mechanism. Many somatic diagnoses point to an empirically identifiable entity, such as a microbe or a tumor, or a pathophysiological process, such as insulin resistance, that explains the symptoms and signs it causes [2, 13-14]. By contrast, diagnostic categories in psychiatry are currently defined only by symptoms. That is, they do not refer to any known pathophysiological processes or specific causes. As stated in the Diagnostic and Statistical Manual of Mental Disorders [15, p. xi], "a complete description of the underlying pathological processes is not possible for most mental disorders"[2].

As Borsboom and Cramer [13] acutely point out, a medical condition can be the cause of symptoms only if the condition is conceptually independent from them. For example, a tumor in the lung can cause symptoms such as cough, fatigue, and shortness of breath, because a tumor is not synonymous with the symptom list itself. One can have a tumor in the lung without (yet) experiencing any symptoms, and, conversely, one can have all these symptoms without having a tumor. By contrast, psychiatric diagnoses are not conceptually independent of their respective symptom lists. Although symptoms must meet the agreed upon criteria to match a given diagnostic label, a patient cannot "have" depression, for example, according to the DSM, if he or she does not experience, or has not experienced, depressed mood or a loss of interest or pleasure—this is how depression is defined. To put it simply, a purely descriptive diagnosis cannot be the cause for its symptoms because it merely

[1] For the purposes of this paper, causation can be defined as 'the relation between cause and effect, or the act of bringing about an effect' [64, p. 110].

[2] There are some exceptions: Substance-induced psychotic disorder, for example, is a psychiatric diagnosis in the DSM-5 which provides both a description and a cause for the symptoms. In this diagnosis, a pattern of substance use *leads* to psychotic symptoms.

describes them: Depression cannot be the cause of depressed mood, just as 'headache', although an existing diagnosis, is not a causal explanation for pain in the head.[3]

This is an entirely uncontroversial point, even a seemingly trivial one. Laypeople, however, often interpret psychiatric diagnoses as *explaining* the symptoms they describe [16, 17]. That is, psychiatric diagnoses are frequently talked about circularly, *as if* they described causes for symptoms. Moreover, a careful reading of authoritative texts in psychiatry shows that the category mistake of confounding causes with descriptions of symptoms is surprisingly common even among professionals [2, 14]. As Read and Moncrieff [18] recently summarized, "depression, for example, is described as somehow *causing* abnormal feelings and behaviors, *as if* it were a physical condition, even though those same feelings and behaviors form the criteria for the diagnosis in the first place".

Understanding where this category error stems from and learning how it could be better avoided is important for ensuring that the public is provided with scientifically accurate information. While there are undoubtedly many ways in which descriptions and causes can become conflated in laypeople's minds, medical authorities and professional organizations play a powerful role in overseeing how the nature of mental illness is societally understood. Their role is particularly important because the quality of mental health information on the internet is generally poor [19-20].

If it is the case that authoritative medical and health institutions mistake descriptive diagnostic labels for causal explanations, the resulting confusion has the potential to mislead the public about the meaning of psychiatric diagnoses.

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[3] It should be noted that although a purely descriptive diagnostic construct logically cannot cause the symptoms it describes, the symptoms can of course cause other things, both separately and in combination: Depressed mood (or a pain in the head) can cause a person not to attend a social event, for example. These effects can in turn naturally cause other things, such as when not attending a social event causes feelings of loneliness or a fear of missing out, which in turn can make a person feel even worse.

The same is true of course for the collection of complaints which, when considered together, meet the DSM criteria for a clinical diagnosis. That is, we are not claiming that the symptoms constituting a major depressive disorder diagnosis—i.e., depressed mood, diminished interest in daily activities, weight loss or increase in appetite, insomnia, psychomotor agitation, loss of energy, feelings of worthlessness, diminished ability to think, and recurrent thoughts of death—could not cause other things, separately or together. In that sense, even though it is logically circular to say that depression caused the person's depressed mood, it is not circular to say that depression caused the person to not attend an event.

Moreover, there is no logical reason that the symptoms among the diagnostic criteria could not cause others that are also among the criteria for the same category. For example, insomnia could (logically) cause loss of energy and changes in appetite, which in turn could (logically) cause a diminished ability to think, for example. It is therefore not logically circular to say that depression can feel like a vicious cycle in which the symptoms can cause and/or exacerbate others. This, however, is a logically different claim from one stating that depression causes depressed mood or insomnia—the same things the construct is meant to describe.

To investigate whether professional institutions may be contributing to how symptom descriptions become confounded with their presumed causes, we analyzed the content of websites from leading, well-known organizations that provide authoritative information about health and psychiatric disorders. We focused specifically on the diagnosis of depression, a 'prototypical' mental illness. We investigated how the causal nature of depression, as a psychiatric diagnostic category, is presented to the public. More specifically, we analyzed whether depression was portrayed scientifically accurately as a purely descriptive label, or whether it was circularly portrayed as causally explaining its symptom criteria.

Methods

To search for the most commonly accessed educational websites providing information on depression, we used Google, the most widely used internet search engine. To ensure replicability of the search, we turned off personalized search results, and used Google Chrome in private browsing (Incognito) mode. The search terms we used were 1) "Depression" 2) "What is depression?" 3) "Clinical depression", and 4) "Major depressive disorder". People using search engines most often limit their search to the first 10 results [21]. To ensure that our sample covered the majority of results that people would be likely to encounter, regardless of individual personal settings and search engine filterings, we selected a larger subset encompassing the first 30 search results of medical professional, (inter)governmental and non-governmental health organizations offering information on mental disorders, including university websites. We focused on organizations in English-speaking Western countries. Advertisements and websites of for-profit companies were excluded.

Our content analysis focused on how the causal relationship between the disorder (depression / major depressive disorder) and the symptoms was presented. We classified all descriptions into three categories: *1. Causally explanatory, 2. Descriptive,* and *3. Unspecified.* The first category consisted of instances in which depression was explicitly presented as causing the symptoms. For example: "Depression causes feelings of low mood, loss of pleasure, fatigue…" In the second, descriptive, we categorized instances in which depression was explicitly presented as merely describing a cluster of symptoms. For example: "Depression describes a pattern of psychiatric symptoms including low mood, loss of pleasure…" In the third, unspecified category, we classified usages in which the nature of the causal relationship was left unclear or unstated, or in which descriptive and causal language were both used. For example: "People with depression experience a low mood, loss of pleasure…"

Results

Of all analyzed websites, 13 were maintained by governmental institutions (e.g., National Institute of Mental Health in the USA, National Health Services in the UK), nine by non-governmental organizations (e.g., National Alliance on Mental Illness, Mind), three by professional psychiatric associations (e.g., American Psychiatric Association), three by universities (e.g., Harvard University), and two by intergovernmental bodies under United Nations (WHO, UNICEF). All selected websites, together with their countries and organizational categories, are displayed in Online Supplementary Materials (Table S1).

Examples of how institutional health authorities described depression are shown in Table 1. Surprisingly, none of the organizations in the analyzed texts presented depression explicitly as a descriptive label for a cluster of symptoms although this would have been scientifically accurate. By contrast, 16 (53%) of the analyzed institutions either explicitly described depression as causally responsible for the symptoms or used language that was both descriptive and causal. For example, The World Health Organization states that depression, a "common illness worldwide… can *cause* the affected person to suffer greatly and function poorly at work, at school and in the family"[4]. The American Psychiatric Association states on their website: "Depression *causes* feelings of sadness and/or a loss of interest in activities you once enjoyed." The remaining 14 (46%) used language that was categorized as unspecified (i.e., neither explicitly claimed depression was causing the symptoms nor pointed out that the diagnosis is descriptive). For example, the Royal College of Psychiatrists states: "Everyone has times in their lives when they feel fed up or miserable… However, if these feelings go on for weeks or months, or become so bad they start to affect every area of your life, you may have depression and need to get help."

[4] The statement is circular because it claims that the descriptive diagnostic construct causes the same symptoms it is meant merely to describe. While this may not be immediately apparent because of the slightly different wording, suffering and/or functioning poorly are required criteria for the DSM diagnosis of major depression: 'B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning' [15, p. 8]. Although the meaning of the expressions "to suffer greatly and function poorly" and (to experience) "significant distress or impairment in… functioning" are not identical, they overlap so substantially that causal language here is circular. Logically, a person cannot experience significant distress and not suffer greatly. It is similarly impossible for a person to experience significant impairment in functioning and not to function poorly. Depression, then, cannot be the cause of the suffering and/or impairment if what the diagnosis means is to experience these things. It is therefore more accurate to say that the diagnosis *describes* forms of suffering/distress and/or impairment, rather than causes them.

[INSERT TABLE 1 HERE]

Discussion

Treating descriptions of symptoms as their causal explanations is a form of circular reasoning. In some of the most prominent health-related websites, the majority of leading health institutions explicitly presented depression as the cause of depressive symptoms. Notably, we found causal portrayals on 53% of all analyzed websites, including those managed by the most authoritative mental health organizations worldwide, such as The World Health Organization, American Psychiatric Association, National Institute of Mental Health, and the National Health Service in the UK. None of the analyzed websites clearly defined depression as a purely descriptive diagnosis, as would have been accurate.

The results show that the core understanding of depression is based on circular logic to a striking degree in the information presented to the public by trusted health institutions. The American Psychiatric Association, in the DSM-5, makes explicitly clear that the diagnostic criteria of mental disorders are descriptive in nature because the underlying pathologies are not known [15, p. XLII]. Yet their own public website claims otherwise. This analysis demonstrates that when seeking to understand what depression is, people are very likely to meet misleading information from leading health authorities. The problem is likely not restricted to depression: Our findings are consistent with prior research which has noted a similar problem regarding authoritative professional messaging regarding ADHD [22].

Why Are Circular Causal Claims Problematic?

The pervasiveness of circular causal claims is concerning. The websites of professional health organizations are a highly impactful form of science communication, and it is important for several reasons that this messaging be scientifically accurate. First, scientific accuracy is critical for maintaining public trust in science and medicine. Misleading information can weaken public trust, which in turn can erode compliance with recommended health behaviors, jeopardizing the success of public health interventions [23].

Second, it is important to be able to identify the source of one’s suffering to respond to it effectively. If people are given inaccurate information about the causes and effects of medical conditions that leads them to misconstrue the sources of their suffering, they will not be able to make informed choices about their lives. While no studies, to our knowledge, have directly investigated the empirical

effects of misleading circular causal claims about mental health by health authorities on the lay public, a recent study which tracked people's strategies for regulating their emotions showed that the better people were aware of the causes of their suffering, the better and the more successful were their strategies for regulating their negative emotions [24]. Evidence also indicates that people are often not aware of the causes of their negative emotions [24], making them vulnerable for misleading causal attributions—especially when these claims are presented as objective biomedical fact.

In the examples shown in this study, lay readers are misleadingly guided to believe that a known pathological disease process, external to their lives, is causing their suffering, when this is in fact not true [13, 22]. This may discourage them from looking for the actual causes of their low mood; disincline them from conceptualizing, understanding, and making meaning of their mental distress [5, 24-26]; and promote prognostic pessimism and impair outcomes [27-30]. Although the circular claims may sound inconsequential at first glance, they may thus effectively hinder emotion regulation by creating an illusory causal explanation that undermines attempts to identify the true sources of the suffering and effectively obscure the links between mental distress, personal history, meaning, and cultural context [5, 18, 22, 24-26].

As Liberati et al. [31] recently pointed out, the ability to contextualize another person's distress is central also for compassion in mental health work. Erroneous causal beliefs erode accurate understandings of mental distress also for clinicians, potentially making it harder to respond to patients' problems effectively with compassion.

Why Are Erroneous Circular Claims So Common?

Why, then, are circular causal claims about depression so commonly endorsed? That it may be difficult immediately to see anything wrong with the identified circular claims at face value is an indication that we as Western societies are (or have become) intuitively quite prone to thinking of depression as something other than a purely descriptive diagnosis – as something that it in fact is not. It is not uncommon in itself for the intuitions of laypeople and even professionals to be at odds with scientific views about causality in mental health problems: A variety of cognitive biases have been identified that affect both everyday and clinical judgment and show that our intuitions about mental health are not always veridical [32-34].

While our data do not speak directly to what has shaped people's intuitions in this case, possible hypotheses can be offered. Conceivably, the error may be rooted in how humans intuitively think

about categories. Psychologically, humans have a well-established tendency to *essentialize* categories—i.e., to believe that categories are unitary, natural, and have an underlying essence that gives category members their identity and is responsible for similarities among members [35-37]. This tendency appears already at an early age in childhood [35], and it not only organizes people's knowledge about the world but also guides them to make generalizations about category members. People are known to essentialize categories of mental illness, among others: Evidence shows that people commonly believe that psychiatric disorders are unitary categories, each having an underlying cause that is responsible for producing the symptoms [32].

Conceivably, this psychological bias may explain why circular claims are so widespread. Considering that people are known intuitively to think that medical disorders are unitary categories that must have a shared underlying cause producing the symptoms, it is perhaps not surprising that a depression diagnosis is commonly confused with a causal explanation for the symptoms. Consistent with this, empirical evidence indirectly suggests that people intuitively interpret descriptive psychiatric diagnoses as containing causal explanations: Qualitative studies show that people often feel conflicted about, or reject their psychiatric diagnosis if they feel that psychosocial factors, life history or life circumstances explain their symptoms [38-42], suggesting that the diagnosis and psychosocial causes are believed to be incongruous with each other.

If this is where the error stems from, the tendency to essentialize disorders in this way seems to be so intuitively compelling that even the leading health authorities have commonly come to treat the descriptive DSM diagnosis of depression as a causal agent. It may sound surprising that health authorities might be subject to similar psychological essentialist biases as the lay public, but it is consistent with the observation that researchers are not immune to them either [37]. In fact, some argue that essentialist biases are a key factor that has impeded scientific progress in psychiatry and clinical psychology and continues to hamper our understanding of mental distress, treatment and effective social policy [37]. Moreover, since people have a tendency to perceive depression as a unitary natural category with a causal essence, it seems likely that the widespread circular claims may further strengthen this intuition, thus making it increasingly difficult for patients, politicians, the public media, patient advocacy groups, and healthcare reformers to distinguish between true and imaginary causal mechanisms.

As a side note, many websites also presented depression as a unitary medical illness, which may further contribute to the essentializing of depression as a cause of symptoms rather than their description. Although presenting depression as a unitary medical disorder is not a logical fallacy like

circular claims are, this emphasis may further exacerbate the misunderstanding that descriptive diagnoses are causal explanations by downplaying the fact that in reality diagnostic categories in psychiatry subsume heterogenous and overlapping phenomena, are not easily separable from adaptive reactions to adverse experiences, and lie on continua with non-clinical phenomena [3, 5, 6, 37, 43-48].

Another possible explanation for the ubiquitousness of circular claims is that professional guild interests may play a role in maintaining them. While it is possible to conceptualize mental distress and mental difference in many ways [e.g. 10, 49-50], psychiatric diagnoses serve to conceptualize forms of mental distress as medical disorders. Being able to provide causal explanations for illnesses is typically seen as a sign of scientific progress in medicine. Thus, the psychiatric discipline as a professional guild may not see it as a priority to publicly emphasize that the field has not discovered any [51-52]. Regardless of other contributing factors, however, circular logic cannot become the rule without a pervasive failure in scientific education – an area which is in need of more societal effort and support. Although the information on many authoritative English-language websites was currently inaccurate, leading health organizations could play an important role in correcting common misperceptions in the future by providing accurate information in their public health messaging.

To be clear, our intention is not to deny the validity or seriousness of any of the human experiences referred to as depression. In a phenomenological sense, these experiences are real, and the symptoms of depression—both separately and in combination—constitute forms of psychological suffering that can be incapacitating and feel outside the individual's direct control. This can phenomenologically *feel* like the presence of an illness, and some people may find it helpful describe their experience as such. While it would be entirely correct to say that the human experiences that the diagnostic criteria describe can *feel like* an illness, it is different from claiming that an identified external biomedical pathological entity is really causing the symptoms.

Ways to Provide Accurate Information About Depression

Fortunately, there are non-circular ways to understand what it means to experience the range of phenomena that often become labeled as depression – including but not limited to narratives based on a biomedical illness framework [10, 49-50]. One of several possible approaches that do not obfuscate the meaning of the diagnosis is simply to be clear about descriptions versus causes. The British Psychological Society (BPS), for example – an organization that was not among the sample of websites we analyzed – uses purely descriptive language in their description of depression, as is scientifically accurate: "Depression is not a word that describes just one state of mind, but refers to a

whole array of different feelings and thoughts…” [25, p. 13], and, “The experience we call depression is a form of distress” [25, p. 16]. It is thus demonstrably not difficult to be clear in public-health messaging about what a descriptive diagnosis means. Recognizing descriptive diagnoses for what they are – mere descriptions of the suffering – provides more room, not less, to explore the various potential ways in which individuals can seek to understand the meaning of their lived experiences.

An alternative non-circular approach is based on the fact that while no unified biological pathological process has been found that causes depression, the number of stressful life experiences is significantly associated with the likelihood of experiencing depression [45, 53]. Some authors therefore emphasize that depression can be described as an adaptive response or a functional signal to adverse circumstances [54-58]. Contrary to the erroneous causal beliefs that circular claims promote, this approach underlines that low mood and/or loss of pleasure are often meaningful reactions to life events, and that they can be meaningfully understood.

This approach is not only scientifically more accurate than claiming that symptoms are caused by their descriptive label, but it also has important beneficial effects for patients in practice. A recent preregistered randomized controlled study showed that framing depression as an adaptive response to life events led to less self-stigma among patients, stronger beliefs in their own agency over their symptoms, and more adaptive beliefs about the symptoms relative to framing it as a medical disorder [54]. This is likely at least in part because attributing the symptoms to an illness external to one’s life reinforces the beliefs that the problem is immutable and that the individual has little or no control over their suffering [59-60]—beliefs that can easily become self-fulfilling prophecies—but perhaps also (in part) because framing the problem as an adaptive response does not impede attempts by the individual to understand the singular sources of their suffering. Clinicians can also counter common misconceptions about depression in targeted ways that are directly helpful for clinical practice, such as emphasizing its controllability [61-62].

An interesting question from the perspective of our study is whether the psychological advantages in the adaptive response -framing might stem (at least in part) from not leading people subtly to confuse descriptions with causes: Since people have a tendency, as mentioned earlier, to essentialize medical disorders as ailments with an underlying cause, the mere framing of depression as a medical disorder might conceivably be enough in itself to suggest implicitly to people that their problems are caused by an external pathological process outside their control. By contrast, the adaptive-response approach may circumvent this problem by avoiding this framing altogether. Future research can

hopefully elucidate what people intuitively understand a medical diagnosis to entail and shed further light on how different framings of depression affect patients, clinicians and the public at large.

Regardless of the details of these psychological mechanisms, however, it would seem psychologically advantageous if health authorities, instead of promoting the circular causal claims identified in our study, either simply made clear that the diagnosis is merely a description, or, alternatively, advised people to construe their symptoms as a functional, adaptive reaction that can be meaningfully understood and responded to. As Mirowsky & Ross summarize: "No one should forget that we are talking about the disturbing or disruptive thoughts, feelings, and behaviors of people, and not about unseen entities that are somehow the cause of it all." [63].

Limitations

While our investigation was not exhaustive, it focused on the highest-ranked authoritative health-related websites in English. Among the other limitations of this study is that we did not conduct a systematic review of authoritative mental health websites, which would have broadened the scope of our results. Instead, we showed that many popular mental health websites, including those that represent arguably the most respected professional organizations worldwide, explicitly described depression as a disorder that causally explains the symptoms by which it is defined. We argue that this rhetoric is not only scientifically inaccurate but also potentially harmful, for reasons we outlined above. Information offered by mental health authorities should clearly state that psychiatric diagnoses are purely descriptive, and primarily intended as administrative and bureaucratic tools. They are not comparable to physical disorders with established causes and should not be presented as such.

Future research should examine whether causal language describing mental illnesses affects beliefs and expectations about prognosis, treatment and recovery. However, it is not only for instrumental reasons for which we argue that health authorities should strive for scientific accuracy in public messaging. Truthfulness is a central intrinsic value in science communication and healthcare, and it is not unreasonable to expect that institutional messaging by healthcare authorities be scientifically accurate.

Statement of Ethics

An ethics statement is not applicable because this study analyzed only publicly available website content.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

Funding Sources

JK has received no funding for this study. JV has received Postdoctoral research grants from Koneen säätiö and Suomen Kulttuurirahasto.

Author Contributions

Both authors have contributed to the conception, design and drafting of the manuscript. Acquisition and analysis of the data was conducted by JK.

Data Availability Statement

Data availability is not applicable to this article as no new data were created or analysed in this study. All website content analyzed in this study is publicly available.

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Table 1: Examples of website content and type of explanation

Description	Source	Type of explanation
"Depression is a common illness worldwide… It can **cause** the affected person to suffer greatly and function poorly at work, at school and in the family.[1] It [depression] can also disturb sleep and appetite." "Depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life."	World Health Organization	Causal
"[Depression] **causes** severe symptoms that **affect** how you feel, think, and handle daily activities, such as sleeping, eating, or working."	National Institute of Mental Health	Causal
"Depression (major depressive disorder) is a common and serious medical illness that negatively **affects** how you feel, the way you think and how you act…"	American Psychiatric Association	Causal

[1] The statement is circular because it claims that the descriptive diagnostic construct causes the same symptoms it is meant merely to describe. While this may not be immediately apparent because of the slightly different wording, suffering and/or functioning poorly are required criteria for the DSM diagnosis of major depression: 'B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning' (APA 2016, p. 8). Although the meaning of the expressions "to suffer greatly and function poorly" and (to experience) "significant distress or impairment in… functioning" are not identical, they overlap so substantially that causal language here is circular. Logically, a person cannot experience significant distress and not suffer greatly. It is similarly impossible for a person to experience significant impairment in functioning and not to function poorly. Depression, then, cannot be the cause of the suffering and/or impairment if what the diagnosis means is to experience these things. It is therefore more accurate to say that the diagnosis *describes* forms of suffering/distress and/or impairment, rather than causes them.

“Depression **causes** feelings of sadness and/or a loss of interest in activities you once enjoyed.”		
“Depression **affects** people in different ways and can cause a wide variety of symptoms. They range from lasting feelings of unhappiness and hopelessness…” ”Some people think depression is trivial and not a genuine health condition. They’re wrong – it is a real illness with real symptoms.”	National Health Service	Causal
”Major depressive disorder is a serious mental illness that **affects** how people feel, think, and go about their everyday tasks. The condition can also impact a person’s sleep habits, appetite, and ability to enjoy life.” “Major depressive disorder isn’t something that eventually “passes.” While most people feel sad at times in their lives, major depression is when a person is in a depressed mood most of the day, nearly every day, for at least two weeks.”	SAMHSA	Causal
“Depression **affects** how people think, feel and act. Depression **makes** it more difficult to manage from day to day and	Better Health Channel	Causal

interferes with study, work and relationships.” ”It’s important to note, everyone experiences some of these symptoms from time to time and it may not necessarily mean a person is depressed.”		
Depression is a mood disorder that **causes** a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems.	Mayo Clinic	Causal
“Everyone has times in their lives when they feel fed up or miserable… However, if these feelings go on for weeks or months, or become so bad they start to affect every area of your life, you may have depression and need to get help.”	Royal College of Psychiatrists	Unspecified
“Everybody goes through "ups and downs" in their lives. Sometimes we use the term "depression", or "depressed" to describe these everyday feelings.” “But the normal experiences of life shouldn't be confused with the serious	Canada.ca	Causal

medical illnesses known as mood disorders.” “They **affect** the entire body and not just the mind. Their physical symptoms can range from fatigue to stomach complaints or muscle and joint pain. Many people never realize that they are suffering from depression.”		
“Depressive disorder, frequently referred to simply as depression, is more than just feeling sad or going through a rough patch. It’s a serious mental health condition that requires understanding and medical care.” “Depression can present different symptoms, depending on the person. But for most people, depressive disorder **changes** how they function day-to-day, and typically for more than two weeks.”	NAMI	Causal
Depression is a low mood that lasts for a long time, and **affects** your everyday life. In its mildest form, depression can mean just being in low spirits. It **doesn’t stop** you leading your normal life but **makes** everything harder to do and seem less worthwhile. At its most severe, depression can be life-threatening because it **can make** you feel suicidal.	Mind	Causal

“Depression is much more than simple unhappiness. Clinical depression, sometimes called major depression, is a complex mood disorder caused by various factors, including genetic predisposition, personality, stress and brain chemistry. While it can suddenly go into remission, depression is not something that people can “get over” by their own effort.”	CAMH	Unspecified
“Clinical depression is a serious medical illness that negatively **affects** how you feel, the way you think and how you act.” “It **can change** your eating habits, how you feel and think, your ability to work and study, and how you interact with people. People who suffer from clinical depression often report that they "don't feel like themselves anymore.” “In fact, clinical depression often **interferes** with a person's ability or wish to get help.”	University of California, Berkeley	Causal
”Depression is a serious mood disorder that **affects** your whole body including your mood and thoughts. It **touches** every part of your life. It’s important to	Johns Hopkins Medicine	Causal

know that depression is not a weakness or character flaw. It's a chemical imbalance in your brain that needs to be treated."		
"Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also **changes** how your body works." " Health care providers do not know the exact causes of depression. It is believed that chemical changes in the brain are responsible."	Medline plus	Causal
"[Major or clinical depression] is a serious medical illness that **affects** how you feel, think and behave." "We know that there are physical changes in the level of certain chemicals in the brains of people who are depressed (these chemicals include serotonin and noradrenaline)."	College of Psychiatrists of Ireland	Causal

Websites retrieved October 10, 2022